



AUTHORIZATION AGREEMENT FOR AUTOMATIC DEPOSIT

I hereby authorize **Trillium Health Resources** to initiate credit entries to my
Checking Savings account indicated below and the bank named below,
hereinafter called **DEPOSITORY**, to credit the same to such account.

Depository Bank Name _____

City _____ State _____

Routing No. _____ Account No. _____

This authority is to remain in full force and effect until **Trillium Health Resources** has confirmed receipt of written notification of termination.

Vendor/Provider Name _____

Contact Name: _____

Full Mailing Address

Phone Number: _____ Fax: _____

Date _____ **Signed** _____

Email address: _____

Please list any additional contacts requiring receipt of email for deposit notifications; Name:

Name: _____ Email: _____

Name: _____ Email: _____

Name: _____ Email: _____

REQUIRED - Please attach the following to your completed form;

- Voided check or letter from the depository bank for authorization purposes
- Current W9 Form with signature and date

Unless instructed otherwise, return completed form along with required documentation to:

Email: FinanceForms@TrilliumNC.org

Fax: 252.215.6876 or

Mail: 144 Community College Road, Ahoskie NC 27910

For internal use only:

Name of requestor _____ **Department:** _____

